

Antioch Parks and Recreation Medication Consent and Release Form

Participant's Name: _____

Parent/Guardian Name(s): _____

Camp Name: _____

Daytime Phone: _____ Other Phone: _____

TO BE COMPLETED BY THE CAMPER'S PHYSICIAN

(Attach a copy of prescription)

Name of Medication: _____

Prescribing Doctor's Name: _____ Phone: _____

Prescribing Doctor's Signature: _____

Dosage / Time: _____

Possible Side Effects _____

Dispensing & Storage Instructions (please be specific): _____

TO BE COMPLETED BY THE CAMPER'S PARENT /LEGAL GUARDIAN

I _____, give permission to the Antioch Parks and Recreation Staff to administer the
(Parent / Legal Guardian Name)

above-described medication to my child: _____ according to the administration and dosage
directions provided by my child's physician above.

Parent / Legal Guardian Signature: _____ Date: _____

I HEREBY KNOWINGLY AND VOLUNTARILY WAIVE, RELEASE AND DISCHARGE THE VILLAGE, ANY AND ALL OTHER PARTICIPATING OR COOPERATING GOVERNMENTAL UNITS, AND THEIR RESPECTIVE OFFICERS, AGENTS, EMPLOYEES, VOLUNTEERS AND INDEPENDENT CONTRACTORS (COLLECTIVELY, THE "RELEASED PARTIES") FROM ANY AND ALL CLAIMS FOR INJURIES, DAMAGES OR LOSS, OF ANY KIND OR SEVERITY WHATSOEVER, WHICH MY CHILD MIGHT SUSTAIN AS A DIRECT OR INDIRECT RESULT OF THE RELEASED PARTIES' ADMINISTRATION OF MEDICATION TO MY CHILD. FURTHER, I SHALL INDEMNIFY, DEFEND AND HOLD HARMLESS THE RELEASED PARTIES FROM ANY AND ALL CLAIMS FOR INJURIES, DAMAGES OR LOSS, OF ANY KIND OR SEVERITY WHATSOEVER, WHICH MIGHT BE SUSTAINED AS A RESULT OF THE RELEASED PARTIES' ADMINISTRATION OF MEDICATION TO MY CHILD.

I HEREBY KNOWINGLY AND VOLUNTARILY WAIVE, RELEASE AND DISCHARGE THE RELEASED PARTIES FROM ANY ACCIDENTAL OR NEGLIGENT VIOLATION OR BREACH OF ANY PRIVACY RIGHTS INJURING TO MYSELF OR MY CHILD, IN STATUTE OR COMMON LAW, OR RELEASE OF ANY PERSONAL MEDICAL INFORMATION, IN WHOLE OR IN PART, FURNISHED TO THE VILLAGE IN RELATION TO THE RELEASED PARTIES' ADMINISTRATION OF MEDICINE TO MY CHILD.

In the event of accident, injury, or sudden illness, I authorize needed medical treatment by a physician and / or hospital to be administered to my child.

Parent / Legal Guardian Signature: _____ Date _____